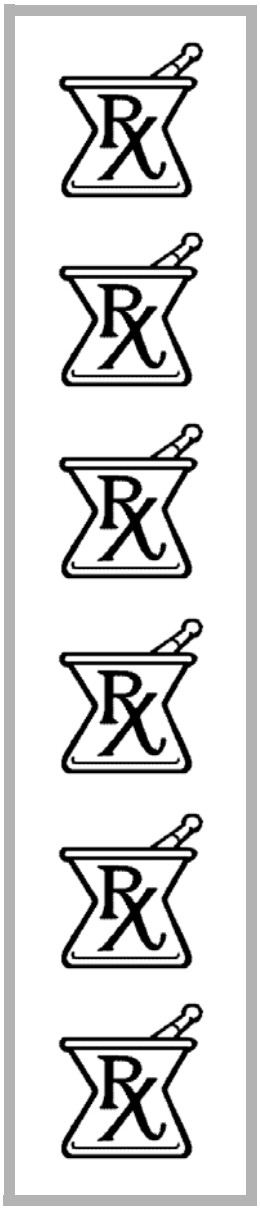

Prescription Drug Prior Authorization

MONTANA
Department of Public Health & Human Services

November 2004

This publication supersedes all previous Drug Prior Authorization handbooks. Published by the Montana Department of Public Health & Human Services, January, 2003. Updated September 2003, July 2004, November 2004.

Prior Authorization

Many drug products require prior authorization (PA) **before** the pharmacist provides them to the client. Requests are reviewed for medical necessity.

- To request prior authorization, providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is at the end of this document.
- The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

  Drug Prior Authorization Unit
  Mountain Pacific Quality Health Foundation
  3404 Cooney Drive
  Helena, MT 59602

  (406) 443-6002 or (800) 395-7961 (Phone)
  (406) 443-7014 or (800) 294-1350 (Fax)

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m. Monday through Friday, or on weekends or holidays are considered received at the start of the next working day.
- An emergency 72-hour supply may be dispensed for emergency after-hours/weekend/holiday requests. Payment will be authorized by using a "3" in the *days supply* field and a Medical Certification code of "8" in the *PA/MC code* field.

Generic Drugs

Prescribers and pharmacies must prescribe and dispense the generic form of a drug, whenever possible. Except for the drugs listed below (*Dispense As Written*), if the brand name drug is prescribed instead of a generic equivalent, the prescriber must get prior authorization. Authorization is based on medical need such as adverse reactions (clinically demonstrated, observed and documented) which have occurred when the generic drug has been used.

Dispense As Written (DAW)

- To bill a brand drug with a generic equivalent, DAW codes 1, 5 and 7 are used.
- DAW 1 may only be used if authorized by the Drug Prior Authorization Unit.
- DAW 5 may be used in instances where the drug dispensed is generic but is listed as a brand (Branded Generics).

- DAW 7 may be used for the following drugs without prior authorization:

  - Lanoxin/Lanoxicaps
  - Coumadin
  - Ritalin
  - Anti-hemophiliac factors
  - Thyroid medications
  - Tegretol
  - Cyclosporine products (i.e. Neoral, Sandimmune)
  - Clozaril
  - Dexedrine products
  - Cylert
  - Imuran
  - Adderal
  - Dilantin
  - Depakote

In addition to prior authorization requirements, brand name drugs with a generic equivalent may be billed only when the prescriber has handwritten "Brand Necessary" or "Brand Required" on the prescription. The pharmacy must retain brand certifications as documentation.

Prior Authorization for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, he or she should present the provider with an FA-455 (eligibility determination letter). Providers may choose whether or not to accept retroactive eligibility (see the *General Information For Providers* manual, *Client Eligibility* chapter). All prior authorization requirements must be met to receive Medicaid payment. It is the client's responsibility to ensure his or her caseworker prepares an FA-455 for each provider who participates in the client's health care during this retroactive period.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider may choose one of the following:

- Refund the client's payment for the service(s) and bill Medicaid for the service(s).
- Retain the client's payment and show it as a credit on the Medicaid claim.

For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Medicaid PA Criteria

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

Medicaid PA Criteria (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.

Disease-Modifying Anti-Rheumatic Drugs (DMARD)
 	
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel whether alone or in combination with methotrexate.
	  • Enbrel or Remicade may be approved with Arava on an individual basis.
	  • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • ≥ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
	  • Remicade therapy will only be approved following a negative
	  • TB test
	  • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.

Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

Medicaid PA Criteria (continued)

Drug	Criteria
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, and Cytotec Prior authorization is required only for concomitant usage of an H2-antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/ milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome. Growth hormone deficiency in adults: • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

Medicaid PA Criteria (continued)

Drug	Criteria
Hypnotic Drugs Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Migraine Headache Drugs For monthly quantities greater than 9 tablets: Imitrex (sumatriptan): 4 injections (2 kits) **or** 6 units of nasal spray Maxalt (rizatriptan) Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan) Zomig nasal spray 6 units Migranal (dihydroergotamine): 4 units Axert (almotriptan) Frova (frovatriptan) Relpax (electriptan) Amerge (naratriptan HCl)	Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Usage of duplicating generic entities are not allowed, but authorization may be approved on an individual basis for concomitant use of differing dosing formulations of the same drug. Concurrent therapy with Stadol will not be covered.
Nonsedating antihistamine products	• Prescribed OTC Loratadine products whose manufacturer has a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) will be available to clients without prior authorization (PA) restrictions. • PA required for federal legend brand and generic non-sedating antihistamines. PA may be authorized upon failure of a fourteen day trial of OTC Loratadine products
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Oxycodone HCL Controlled-Release (OxyContin)	Prior authorization is required for all dosing above twice a day and above 320 mg per day.

Medicaid PA Criteria (continued)

Drug	Criteria
Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of intermittent claudication as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.
Proton Pump Inhibitors (PPI's) Prevacid NapraPac	Federal legend, brand and generic Proton Pump Inhibitors (PPI's) may be authorized upon failure of Prilosec OTC 20mg at doses that exceed 40mg per day. Special consideration may be given on an individual basis for patients requiring specific dosing regimens based on the various PPI formulations. Requires that the patient must have tried and failed concomitant use of Prilosec OTC and Naproxen.
Smoking Cessation Drugs Nicotine-replacement products. Patches are the preferred course of therapy. The gum, lozenge and inhaler replacement therapies are only authorized for patients having allergies or intolerance to the patch adhesive. Zyban (buproprion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.

Medicaid PA Criteria (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

MHSP Prior Authorization Criteria

Drug	Criteria
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy **Please Type or Print**

PATIENT NAME (Last) (First) (Initial)		PATIENT MEDICAID I.D. NUMBER	DATE OF BIRTH
			MONTH DAY YEAR
PHYSICIAN PROVIDER #	PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST	
		FROM	TO
PHYSICIAN NAME		MONTH DAY YEAR	MONTH DAY YEAR
PHYSICIAN STREET ADDRESS		**MAIL, FAX OR PHONE COMPLETED FORM TO:**	
PHYSICIAN CITY STATE ZIP		**DRUG PRIOR AUTHORIZATION UNIT MOUNTAIN-PACIFIC QUALITY HEALTH 3404 COONEY DRIVE HELENA, MT 59602 (406) 443-6002 or 1-800-395-7961 (PHONE) (406) 443-7014 or 1-800-294-1350 (FAX)**	
PHARMACY PROVIDER NO.	PHARMACY PHONE #		
PHARMACY NAME			
PHARMACY STREET ADDRESS			
PHARMACY CITY STATE ZIP			

DRUG TO BE AUTHORIZED

DRUG NAME	STRENGTH	DIRECTIONS

DIAGNOSIS OR CONDITION TREATED BY THIS DRUG

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.

APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER